

## 724

Item 7 Film G238 1-28-59 et

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Hebron</b>		c. LENGTH OF STAY IN 1b <b>Ellicott City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Hebron</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH W. ALLEN</b>		4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>47</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>H. J. Baker, Ellicott City, Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Apoplectic Hemorrhage of Left Cerebellar Hemisphere</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>331x</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr., M.D.</b>		DATE SIGNED <b>1/20/59</b>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>West Liberty</b>		22d. LOCATION (City, town, or county) (State) <b>Alpha, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR <b>JAN 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-1-23

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
EDUCATION: [illegible]  
OCCUPATION: [illegible]  
MARRIED: [illegible]  
SINGLE: [illegible]  
WIDOWED: [illegible]  
DIVORCED: [illegible]  
REMARKS: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE: [illegible]

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00717

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenwood</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH ANN COTTON</b>				4. DATE OF DEATH Month Day Year <b>Jan. 20 1959</b>											
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-26-1953</b>		9. AGE (In years last birthday) <b>5 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>John Cotton</b>				14. MOTHER'S MAIDEN NAME <b>Marion Hoglund</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Cotton, Glenwood, Md</b>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cremation <del>by</del> in burning house</b> <b>916.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Dwelling burned to ground</b>											
20c. TIME OF INJURY Month, Day, Year Hour <b>1.45 AM</b> <b>1-20-59</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Glenwood</b>		(County) <b>Howard</b>		(State) <b>Md</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>George E. Burgtorf</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED							
EXAMINER'S NAME (Type) <b>George E. Burgtorf</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				22b. DATE THEREOF <b>1-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md</b>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>						ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 23 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

152

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>		<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>RESIDENCE</p>		<p>PLACE OF BIRTH</p>		<p>EDUCATION</p>		<p>OCCUPATION</p>		<p>RELIGION</p>		<p>DATE OF MARRIAGE</p>	
<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>		<p>PLACE OF DEATH</p>		<p>DATE OF EXAMINATION</p>		<p>TIME OF EXAMINATION</p>		<p>TIME OF DEATH</p>	
<p>DIAGNOSIS</p>		<p>POST-MORTEM EXAMINATION</p>		<p>TOXICOLOGICAL EXAMINATION</p>		<p>ANTHROPOLOGICAL EXAMINATION</p>		<p>FORENSIC EXAMINATION</p>		<p>OTHER EXAMINATIONS</p>	
<p>TESTS</p>		<p>RESULTS</p>		<p>COMMENTS</p>		<p>SIGNATURE OF EXAMINER</p>		<p>DATE OF SIGNATURE</p>		<p>TIME OF SIGNATURE</p>	

## CERTIFICATE OF DEATH

Reg. Dist. No.

726

1. PLACE OF DEATH o. COUNTY <i>Howard</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 03x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Schaeffer Retreat</i>		d. STREET ADDRESS <i>8636 Old Harford Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Mary R. V. Dailey</i>		4. DATE OF DEATH Month Day Year <i>January 21st 19 59</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 13, 1872</i>
9. AGE (In years last birthday) <i>86</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>David Myers</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Taaband</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs Anna Dailey, 2815 Rueckert Avenue</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Atherosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>acute</i> <i>?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1</i> , 19 <i>58</i> , to <i>Jan. 21</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Jan 19</i> , 19 <i>59</i> , and that death occurred at <i>8:34</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1037 W. Calvert St Baltimore 24d</i> DATE SIGNED			
ACTUAL SIGNATURE <i>Dr. L. A. Kochman</i>		M.D. <i>1037 W. Calvert St Baltimore 24d</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/23/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR DATE <i>JAN 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00719

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>HOWARD</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural - Clarksville</b>		c. LENGTH OF STAY IN 1b <b>instant.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Dorothy</b> Middle <b>Virginia</b> Last <b>ESTEP</b>		<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>2</b> Year <b>19 59</b>	
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>colored</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 14, 1914</b>
<b>9. AGE</b> (In years last birthday) <b>44 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>house maid</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>private home</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Frank Thomas Wilson</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Laura Rebecca Henson</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>215305230</b>	
<b>17. INFORMANT</b> <b>Jesse Wilson, Highland, Maryland</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>Severe crushing injury to chest (auto acc.) instant.</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b>	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased driving car, skidded on ice and ran into tree. Steering wheel crushed chest.</b>		<b>20c. TIME OF INJURY</b> Month, Day, Year <b>8:45 a.m. 1-2- 1959</b>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>State Road</b>	
<b>20f. (City or town)</b> <b>Clarksville, Howard, Md.</b>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
<b>ACTUAL SIGNATURE</b> <i>Charles S. Whitaker</i> <b>M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <b>Charles S. Whitaker, M.D.</b>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <b>January 2, 1958</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>1/6/59</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Hopkins Church,</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Highland, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Robert L. Sumner</i>		<b>24a. REC'D BY REGISTRAR</b> <b>JAN 8 '59</b>	
<b>ADDRESS</b> <b>Rockville, Md.</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Howard</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "White"]	
DATE OF DEATH [Faint text, possibly "10/15/1918"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CITY AND COUNTY [Faint text, possibly "Baltimore, Maryland"]		OCCUPATION [Faint text, possibly "Teacher"]	
CAUSE OF DEATH [Faint text, possibly "Pneumonia"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF EXAMINER [Faint signature]		DATE [Faint text, possibly "10/15/1918"]	
SIGNATURE OF WITNESS [Faint signature]		DATE [Faint text, possibly "10/15/1918"]	

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

Reg. Dist. No.

00720

728

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. LENGTH OF STAY IN 1b <b>Ellicott City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Thunder Hill</b>				e. STREET ADDRESS <b>Thunder Hill</b>			
3. NAME OF DECEASED (Type or print) <b>Anna Mae</b> First <b>ANNE</b> Middle <b>H.</b> Last <b>GOLDSMITH</b>				4. DATE OF DEATH <b>Jan. 9, 1959</b> Month <b>Jan</b> Day <b>9</b> Year <b>19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 10, 1925</b>	
9. AGE (In years last birthday) <b>33</b> yrs.		IF UNDER 1 YEAR Months <b>33</b> Days <b>33</b> Hours <b>33</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Unknown Amoss W. Herrmann</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Margaret ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address <b>C. Oliver Goldsmith, Ellicott City, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC BRAIN CANCER</b> DUE TO (c) <b>CANCER OF BREAST</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS</b> <b>19 MOS</b> <b>13 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-8</b> 19 <b>59</b> , to <b>1-9</b> 19 <b>59</b> , that I last saw the deceased alive on <b>1-8</b> 19 <b>59</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1-9-59</b>							
ACTUAL SIGNATURE <b>Peter V. Thorpe</b> M.D.				DATE SIGNED <b>1-9-59</b>			
PHYSICIAN'S NAME (Type) <b>PETER V. THORPE MD</b>				<b>ELLICOTT CITY, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Louis</b>		22d. LOCATION (City, town, or county) (State) <b>Clarksville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 12 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>JOHN J. ROBERTS</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>	
4. PLACE OF BIRTH <b>NEW YORK</b>		5. DATE OF BIRTH <b>1915</b>		6. PLACE OF DEATH <b>BALTIMORE</b>	
7. OCCUPATION <b>LABORER</b>		8. CAUSE OF DEATH <b>HEART DISEASE</b>		9. MANNER OF DEATH <b>NATURAL</b>	
10. DATE OF DEATH <b>1960</b>		11. TIME OF DEATH <b>10:00 AM</b>		12. PLACE OF INTERMENT <b>CATHOLIC CHURCH</b>	
13. NAME OF PHYSICIAN <b>DR. J. H. ROBERTS</b>		14. NAME OF FUNERAL HOME <b>JOHN J. ROBERTS</b>		15. NAME OF MINISTER <b>FRANK J. ROBERTS</b>	
16. NAME OF NEXT OF KIN <b>MARY J. ROBERTS</b>		17. ADDRESS OF NEXT OF KIN <b>1234 E. BALTIMORE</b>		18. CITY AND STATE <b>BALTIMORE, MD.</b>	
19. NAME OF DECEASED'S MOTHER <b>MARY J. ROBERTS</b>		20. NAME OF DECEASED'S FATHER <b>JOHN J. ROBERTS</b>		21. NAME OF DECEASED'S SPOUSE <b>JOHN J. ROBERTS</b>	
22. NAME OF DECEASED'S CHILDREN <b>JOHN J. ROBERTS</b>		23. NAME OF DECEASED'S SIBLINGS <b>MARY J. ROBERTS</b>		24. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
25. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		26. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		27. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
28. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		29. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		30. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
31. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		32. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		33. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
34. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		35. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		36. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
37. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		38. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		39. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
40. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		41. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		42. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
43. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		44. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		45. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
46. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		47. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		48. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
49. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		50. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		51. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
52. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		53. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		54. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
55. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		56. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		57. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
58. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		59. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		60. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
61. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		62. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		63. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
64. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		65. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		66. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
67. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		68. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		69. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
70. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		71. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		72. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
73. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		74. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		75. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
76. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		77. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		78. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
79. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		80. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		81. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
82. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		83. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		84. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
85. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		86. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		87. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
88. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		89. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		90. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
91. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		92. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		93. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
94. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		95. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		96. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
97. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		98. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		99. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	
100. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		101. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>		102. NAME OF DECEASED'S OTHER RELATIVES <b>JOHN J. ROBERTS</b>	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00721

Reg. Dist. No.

729

1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN ANDREW HOLLAND</u>		4. DATE OF DEATH Month Day Year <u>Jan. 29, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 12, 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Highland, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Highland, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Grafton Holland</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-1270</u>	
17. INFORMANT <u>Laura Wilson, Highland, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status Epilepticus due to Cerebral Arterio-</u> <u>334 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>sclerosis</u> (c) <u>scloresis</u> (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Donald E. Fisher</u> EXAMINER'S NAME (Type) <u>Donald E. Fisher</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-29-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopkins Church, Highland, Md</u>		22d. LOCATION (City, town, or county) (State) <u>Highland, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surden</u>		24a. REC'D BY REGISTRAR <u>FEB 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Klaus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home or. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elbridge</i>		c. LENGTH OF STAY IN 1b <i>3 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1808 Montgomery Road</i>		d. STREET ADDRESS <i>1808 Montgomery Road</i>	
3. NAME OF DECEASED (Type or print) <i>FRANKLIN HENRY JONES</i>		4. DATE OF DEATH <i>Jan 20 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 22, 1874</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Conductor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired Penn. R.R.</i>	
11. BIRTHPLACE (State or foreign country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jones</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Russell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no.</i>	
17. INFORMANT <i>Mr Charles H. Steele</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Myocarditis</i> DUE TO <i>General arteriosclerosis</i> (c) <i>Sanclivity</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 hrs</i> <i>3 1/2 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 16 1939</i> , to <i>Jan 20 1959</i> , that I last saw the deceased alive on <i>Jan 20 1959</i> , and that death occurred at <i>4:18 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>B B Bumbaugh</i> M.D.		ADDRESS (Street, city or town, state) <i>5609 main st 1/21/59</i>	
DATE SIGNED <i>1/21/59</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>B B Bumbaugh</i>		ADDRESS <i>Elbridge 27 Ma</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 23, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mossberg Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Liberty Center Ind.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins &amp; Sons, Co.</i>		ADDRESS <i>4905 York Road</i>	
24a. REC'D BY REGISTRAR <i>DATE JAN 23 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>	

CERTIFICATE OF DEATH

Form 100-10-1

1. Name of deceased: John Doe

2. Sex: Male

3. Race: White

4. Date of birth: 1/1/1900

5. Date of death: 12/1/1950

6. Place of death: Home

7. Cause of death: Heart Disease

8. Signature of physician: Dr. J. Smith

9. Signature of registrar: John Doe

10. Signature of informant: John Doe

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00723

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Howard</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Howard</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>126 Main St.</u>				d. STREET ADDRESS <u>126 Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>G.</u> Last <u>McCauley</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-18-1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Station Attd.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gasoline</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? 							
13. FATHER'S NAME <u>Walter Mc Cauley</u>				14. MOTHER'S MAIDEN NAME <u>Susan Allison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>216-10-4909</u>		17. INFORMANT <u>Mrs. Edith Mc Cauley, Ellicott City, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-28-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>				ADDRESS <u>Ellicott City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00724

732

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel rural</b> c. LENGTH OF STAY IN 1b <b>Laurel rural</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 1 Box 24</b>		d. STREET ADDRESS <b>Rt. 1 Box 24</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DENNIS MOORE</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 1879</b> 9. AGE (In years last birthday) <b>79</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Laurel, Md</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>Dennis Moore</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Thos. Snell</b>		Address <b>Laurel, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Viral Gastro enteritis</b> <b>571.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Donald E. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> (Columbia Pike) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Ellicott City) DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>1-3-59</b>	
EXAMINER'S NAME (Type) <b>Donald E. Fisher</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/6/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Beacons Chaple</b>	22d. LOCATION (City, town, or county) (State) <b>Laurel Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Selby</b>		ADDRESS <b>Laurel, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Donald E. Fisher</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

332

DEATH NO. 1

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF DEATH		7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF EXAMINER		12. SIGNATURE OF WITNESS		13. SIGNATURE OF CLERK		14. SIGNATURE OF JURY		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CORONER		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CONSTABLE		19. SIGNATURE OF TOWNSHIP CLERK		20. SIGNATURE OF COUNTY CLERK	
21. SIGNATURE OF STATE CLERK		22. SIGNATURE OF DEPARTMENT CLERK		23. SIGNATURE OF HEALTH COMMISSIONER		24. SIGNATURE OF GOVERNOR		25. SIGNATURE OF ATTORNEY GENERAL	
26. SIGNATURE OF JUDGE OF THE COURT		27. SIGNATURE OF JURY		28. SIGNATURE OF CLERK		29. SIGNATURE OF JURY		30. SIGNATURE OF CLERK	
31. SIGNATURE OF JURY		32. SIGNATURE OF CLERK		33. SIGNATURE OF JURY		34. SIGNATURE OF CLERK		35. SIGNATURE OF JURY	
36. SIGNATURE OF CLERK		37. SIGNATURE OF JURY		38. SIGNATURE OF CLERK		39. SIGNATURE OF JURY		40. SIGNATURE OF CLERK	
41. SIGNATURE OF JURY		42. SIGNATURE OF CLERK		43. SIGNATURE OF JURY		44. SIGNATURE OF CLERK		45. SIGNATURE OF JURY	
46. SIGNATURE OF CLERK		47. SIGNATURE OF JURY		48. SIGNATURE OF CLERK		49. SIGNATURE OF JURY		50. SIGNATURE OF CLERK	
51. SIGNATURE OF JURY		52. SIGNATURE OF CLERK		53. SIGNATURE OF JURY		54. SIGNATURE OF CLERK		55. SIGNATURE OF JURY	
56. SIGNATURE OF CLERK		57. SIGNATURE OF JURY		58. SIGNATURE OF CLERK		59. SIGNATURE OF JURY		60. SIGNATURE OF CLERK	
61. SIGNATURE OF JURY		62. SIGNATURE OF CLERK		63. SIGNATURE OF JURY		64. SIGNATURE OF CLERK		65. SIGNATURE OF JURY	
66. SIGNATURE OF CLERK		67. SIGNATURE OF JURY		68. SIGNATURE OF CLERK		69. SIGNATURE OF JURY		70. SIGNATURE OF CLERK	
71. SIGNATURE OF JURY		72. SIGNATURE OF CLERK		73. SIGNATURE OF JURY		74. SIGNATURE OF CLERK		75. SIGNATURE OF JURY	
76. SIGNATURE OF CLERK		77. SIGNATURE OF JURY		78. SIGNATURE OF CLERK		79. SIGNATURE OF JURY		80. SIGNATURE OF CLERK	
81. SIGNATURE OF JURY		82. SIGNATURE OF CLERK		83. SIGNATURE OF JURY		84. SIGNATURE OF CLERK		85. SIGNATURE OF JURY	
86. SIGNATURE OF CLERK		87. SIGNATURE OF JURY		88. SIGNATURE OF CLERK		89. SIGNATURE OF JURY		90. SIGNATURE OF CLERK	
91. SIGNATURE OF JURY		92. SIGNATURE OF CLERK		93. SIGNATURE OF JURY		94. SIGNATURE OF CLERK		95. SIGNATURE OF JURY	
96. SIGNATURE OF CLERK		97. SIGNATURE OF JURY		98. SIGNATURE OF CLERK		99. SIGNATURE OF JURY		100. SIGNATURE OF CLERK	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

733

CERTIFICATE OF DEATH

Reg. Dist. No.

00725

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto. (7)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaffers Conv. Home, Ellicott City</b>		d. STREET ADDRESS <b>5206 Overcrest Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Maggie</b> Middle <b>M.</b> Last <b>Roberts</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1874</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip Airey</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Mentzel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>INFORMANT (DAUGHTER) Mrs. Hazel Lumpkin, 5206 Overcrest Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Hypertensive Arteriosclerosis of Brain</b> DUE TO <b>?</b> (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1</b> , 19 <b>58</b> , to <b>Jan. 13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 12</b> , 19 <b>59</b> , and that death occurred at <b>2:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jan A. Kothman</b>		DATE SIGNED <b>12/4/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. L. A. Tochner</b>		<b>Baltimore 2-4nd</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 15/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Pk.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore 29-11</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b>		24a. REC'D BY REGISTRAR <b>24b. REGISTRAR'S SIGNATURE</b>	
ADDRESS <b>4101 Edmondson A</b>		DATE <b>JAN 19 59</b>	

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734  
CERTIFICATE OF DEATH

00726

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. # 3</b>				d. STREET ADDRESS <b>R.F.D. # 3</b>			
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>Marie</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1895</b>	9. AGE (In years last birthday) <b>63</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jonathan E. Moxley</b>				14. MOTHER'S MAIDEN NAME <b>Mary O'Sullivan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. Willard R. Smith, Mt. Airy, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 10, 1955</b> to <b>January 23, 1959</b> , that I last saw the deceased alive on <b>January 21, 1959</b> , and that death occurred at <b>2:10 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James P. Kerr</b>				ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>		DATE SIGNED <b>1/22/59</b>	
PHYSICIAN'S NAME (Type) <b>James P. Kerr, M.D.</b>				<b>Damascus, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 24, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Airy, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Moleworth</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 27 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Death 1971		Decedent's Name [Illegible]	
Date of Birth [Illegible]		Sex Male	
Race White		Marital Status Married	
Usual Residence [Illegible]		Place of Death [Illegible]	
Cause of Death [Illegible]		Manner of Death Natural	
Physician's Name [Illegible]		Hospital Name [Illegible]	
Date of Death [Illegible]		Time of Death [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	

This certificate is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy of the same is to be furnished to the family of the decedent. The death of the decedent is hereby certified to be a natural death, and the cause of death is hereby certified to be [Illegible].

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLENWOOD</b>				c. LENGTH OF STAY IN 1b <b>9 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>NEW YEARS GIFT FARM</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RODERICK</b> Middle <b>DOWS</b> Last <b>WATSON</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>4</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/17/97</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner of Wholesale plumbing supplies</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>RODERICK D. WATSON</b>				14. MOTHER'S MAIDEN NAME <b>ALICE DOWS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW # 1 225-05-1858</b>		17. INFORMANT Address <b>Mrs. Angela R. Watson, Glenwood, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY ARTERY OCCLUSION</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN.</b> <b>5 MIN.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>NOVEMBER 2</b> , 19 <b>57</b> , to <b>JANUARY 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>JANUARY 2</b> , 19 <b>59</b> , and that death occurred at <b>5:45 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>C. S. Whitaker, M. D.</b>				PHYSICIAN'S NAME (Type) <b>C. S. WHITAKER, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>1/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>	
22d. LOCATION (City, town, or county) <b>ARLINGTON, VIRGINIA</b>				22e. (State) <b>MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. POMEROY, INC.</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 7 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

00728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>	
c. LENGTH OF STAY IN lb <u>23 yrs</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>Irene</u> Middle <u>Wheatley</u> Last		4. DATE OF DEATH <u>January 9</u> 19 <u>59</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 10, 1906</u> 9. AGE (In years last birthday) <u>52</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (State or foreign country) <u>Beaufort, Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>William Curry</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Rodifer</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>James M. Wheatley, Laurel Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>200.1 Lymphosarcoma</u> DUE TO (b) <u>Genitoleysal-Melastosis</u> DUE TO (c) <u>Emaciation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 yr</u> <u>2 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ventricular Fibrillation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/21</u> 19 <u>57</u> , to <u>1/9</u> 19 <u>59</u> , that I last saw the deceased alive on <u>1/9</u> 19 <u>59</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. P. Warren</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel Md</u> DATE SIGNED <u>1/9/59</u>	
PHYSICIAN'S NAME (Type) <u>B. P. WARREN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Medford</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hume</u> ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hume</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> DATE <u>JAN 16 '59</u>	

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